

2200 Opitz Blvd, Ste 335
Woodbridge, VA 22191
Patient Registration Form:

www.dr-sanjeev-kohli.com

Personal Information

Social Security #: _____ Date of Birth: ___/___/___ Age: ___ Sex: M F Marital Status: M S W D

Patient's Name: Last _____ First _____ Mi _____

Patient's Address: _____ Apt#: _____

City: _____ State: _____ ZIP: _____

Home Telephone: _____ Work Telephone: _____ Ext _____ Cell: _____

Employer: _____ Occupation _____

Employment Address _____ City: _____ State: _____ ZIP: _____

Emergency Contact _____ Tel _____ Relationship _____

Patients under the Age of 18

Parent or Guardian Name: Last _____ First _____ Mi _____

Home Telephone: _____ Work Telephone: _____ Ext _____ Cell: _____

Insurance Information

Plan Name: _____ Effective Date: ___/___/___ Primary Secondary

ID # _____ Group # _____ Plan Telephone _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ D.O.B ___/___/___ SS#: _____ - _____ - _____

Policy Holder's Employer _____ Relationship to Patient _____

Plan Name: _____ Effective Date: ___/___/___ Primary Secondary

ID # _____ Group # _____ Plan Telephone _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ D.O.B ___/___/___ SS#: _____ - _____ - _____

Policy Holder's Employer _____ Relationship to Patient _____

Source of Referral

Whom Can We Thank For the Referral (Name)

- Physician: _____
- Insurance Company: _____
- Family/Friend: _____
- Phone Book: _____
- Internet: _____
- Other: _____

Other Information

Do you have an Advance Medical Directive?

Yes No

If yes, please provide a copy for your record; If No, please ask for information.

May we contact you to confirm your appointment?

Yes No

If yes, please indicate preferred Means of Contact and circle 1-2-3 in order of priority

Telephone. # _____ Email Address: _____ Text: _____

Is it okay to leave a Message on your voice mail reminding you of your appointment? Yes No

Assignment of Benefits and Authorization to Release Medical Information

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: Sanjeev Kohli M.D.,PC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance within 45 days. Should it become necessary to turn my account over to an outside collection agency I will be responsible for collection cost, attorney fees, litigation fees and court costs. I hereby authorize Sanjeev Kohli M.D.,PC and its employees and agents, to release all information, reports and records if necessary to secure the payment of my account, including a discussion of my medical condition, to the insurance provider, rehabilitation provider, employer, hospitals, and doctors.

Signature

Patient/ Policy Holder

Date

Responsible Person if Patient is a Minor: _____